''New clinical skills'' of quality management[3]

- Ability to perceive and work in interdependencies
- Ability to work in teams
- Ability to understand work as a process
- Skills in collection, aggregation and analysis of outcome data
- Skills in ''designing'' health care practices
- Skills in collection, aggregation and analysis of data on process of work
- Skills in collaborative exchange with patients
- Skills in collaborative exchange with lay managers

Clinicians coming through such programmes should be better equipped to offer safer care in today's healthcare environment and, if hospitals provide the appropriate support and environment, will be able to put this training into practice. Most of those currently practising will not have had this training. These skills should be included within the revalidation and appraisal processes.

In the past, ignoring organisational rules and norms did not pose much danger to patients. As Cyril Chantler wrote: ''*Medicine used to be simple, ineffective and relatively safe; now it is complex, effective and potentially dangerous*''.[6] Hospitals as organisations need to work with clinicians to make sure that organisational guidelines are respected and adhered to. Insisting on hand hygiene would be a good start. To achieve this will require significant cultural change—and it demands clinical leadership and organisational commitment and support. But it might just be the break that is needed to encourage development of a culture in which organisational guidelines are observed. Hospitals, too, could take responsibility for ensuring that newly qualified doctors, who are very knowledgeable about drugs and therapeutics, learn how to prescribe safely—perhaps under the auspices of a ''Director of Prescribing''[7] It is never comfortable insisting that ''rules'' should be kept. Clinical practice is one area where they are not there to be broken.

This journal has reflected the development of quality and safety improvement for 13 years. Undoubtedly, much more is now known and understood about the extent of problems and some of the underlying causes. Important documents, including the two reports from the US Institute of Medicine, have influenced thinking and shaped the debate about the quality and safety of care worldwide. In the UK we have seen the implementation of clinical governance; the development of National Service Frameworks for a range of conditions and client groups; and the setting up of agencies such as the National Patient Safety Agency and the National Institute of Clinical Excellence. All this seems worlds away from the UK Medical Audit Programme, implemented in 1990 just before the launch of this journal, yet it is not clear just how much patients have benefited from all of this activity. Nevertheless, the increasing concern about the quality and safety of care and a developing research agenda[8] should be grounds for cautious optimism.

The editorial team of *QSHC* is about to change. I hope that the new team will get the opportunity to report groundbreaking changes that show that knowledge about ''what to do'' has at last been translated into significant actions that truly make a difference for patients. In the meantime I thank the many authors, reviewers, and the editorial team who together enabled *QSHC* to reflect the burgeoning debate on quality and safety improvement over the past 13 years.

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Quality improvement in the US and UK

The improvement horse race: bet on the UK

D M Berwick

The task of building the best healthcare system in the world is well started in the UK

Place your bets. Both the UK and the US are struggling to improve their troubled healthcare systems. Which is more likely to succeed? The two countries are strikingly similar in the problems they face, and equally dissimilar in their plans of action. I am a fan of both but, when bets are placed, my money will be on the UK.

The best problem list for either country is probably the one in the landmark 2001 report ''*Crossing the Quality Chasm*'' issued by the Institute of Medicine (IOM), a branch of America's National Academies of Science.[1] Summarizing decades of health services research and literally thousands of studies, the *Chasm* report recommended six ''aims for improvement'' as targets for the redesign of healthcare systems:

- safety (reducing medical injuries to patients);
- effectiveness (increasing the reliability of evidence based care);
- patient centeredness (giving patients and carers far more voice, control, and competence in self-management);

- timeliness (reducing waits and delays throughout the system);
- efficiency (reducing the total cost of care); and
- equity (closing racial and socioeconomic gaps in health status).

Rearranging the first letters, some organizations have taken to calling these the ''S-T-E-E-E-P'' goals.

Although the IOM's report addressed only American health care, its findings—and especially the six aims for improvement—pertain well to the UK and the NHS. The ongoing massive UK effort to improve the NHS—launched as the so-called ''*Modernisation Plan*'' in 1997—has involved massive new investments (raising the total UK expenditures on health care from its starting place of about 6.5% of the GDP closer to the EU average of about 8.5%; compared with 15% in the US!) and the creation of focused strategic plans—National Service Frameworks—that lay out dozens of new targets and approaches to care improvement for a variety of important clinical areas. The National Service Frameworks speak much the same language as the *Chasm* report, with a good deal more precision.

The profile of relative importance of the six aims differs somewhat between the two countries. Equity and excessive cost are far more urgent problems in the US, while timeliness ranks at the top of the NHS improvement agenda. Problems in safety, effectiveness, and patient centeredness plague us both. Overall, however, both nations can with confidence focus on the same ''STEEEP'' list of aims as a worthy agenda.

Why would I bet on success in the UK over the US? The biggest reason is simple: the UK has people in charge of its health care—people with the clear duty and much of the authority to take on the challenge of changing the system as a whole. The US does not. When it comes to health care as a nation, the US is leaderless. An immense resource for progress in improving the NHS—the key resource, in my view—has been the consistent focus of government, emanating from the Prime Minister personally, on raising the bar for NHS performance. The modernisation process sought to establish accountabilities, structures, resources, and schedules in the NHS that no one at all is in a position to establish in the pluralistic, chaotic, leaderless US healthcare system.

No one is thoroughly happy in the UK with the NHS modernisation program to date; it has stumbled occasionally, as any project of that level of ambition must. But no honest observer can fail to credit the process with immense productive change, headed for real measurable successes in a behemoth system that could easily seem unchangeable. Several objective evaluations—of which the most important is that sponsored by the Nuffield Trust in 2003[2]—find substantial gains underway in access, reliability, safety, and outcomes of NHS care. In the especially important arena of patient safety, the clear headed and courageous leadership of England's CMO, Sir Liam Donaldson, and the founding of the National Patient Safety Agency as a national resource, may soon catapult England into international prominence in systematically achieving new and unprecedented levels of patient safety.

> ''Three tough issues lie between the good successes that are almost in hand and the great ones that could be.''

So, I will bet on the Brits. But I would offer even longer odds in their favor if a few large changes were made in the agenda for improvement of the NHS. Three tough issues lie between the good successes that are almost in hand and the great ones that could be.

Unifying improvement work at the health economy level

As an outsider, I would have thought that the globally funded, governmentally sponsored nature of the NHS would lead unerringly to sound development of community wide systems for the care of chronically ill people across the continuum of care. I would have thought that hospitals, community agencies, and primary care trusts—having, in effect, the same ''owner'' and ''employer'' (the public) and drawing on the same common pool of taxation—would work together seamlessly to assure flow, efficiency, integrated experiences, and common aims. But this is not the case. To my surprise, and to the UK's loss, hospitals and primary care trusts at the community level—the so-called ''health economy'' level—remain too often strangers, uncoordinated, mistrusting each other, convinced of conflicting aims, and thereby failing to achieve the needed flow and coordination of care for patients in desperate need of both. The NHS's long hospital lengths of stay and the feelings of disenfranchisement of chronically ill patients and carers, are only some of the symptoms of fragmentation.

The NHS will not achieve its full potential—the ''STEEEP'' goals will remain out of reach—unless and until the primary care trusts and hospitals at the community level are somehow brought more effectively into a common frame of planning, action, and patient care. Only a few local economies have shown success in this, due usually to nearly heroic leadership and hard work to maintain fragile coalitions. That plan is not robust enough for the nation as a whole. I do not necessarily recommend the rediscovery of the ancient ''health authorities'' as a vehicle, but some vehicle must be found to unify actions across the continua of care, or fragmentation will remain.

Achieving authentic patient centeredness

To a visiting American, consumerism and world class customer service seem a bit less developed in the UK than in the US. The same is true in health care. Viewed through American eyes, the modal British patient seems willingly more passive, and the modal British clinician habitually more controlling, than is probably best for either. The *Chasm* report uses the awkward term ''patient centeredness'' to denote the constellation of qualities of care that can give patients and carers power, knowledge, dignity, self-efficacy skills, respect for their diversity, and freedom of action. This is more than a political agenda (though it has political overtones); much sound clinical research shows that empowered, informed, activated patients tend to have much better outcomes and to use healthcare resources much more effectively than patients made helpless, silent, or passive by a system that takes too much control from them.

The NHS modernisation process still lacks a thorough commitment to patient centeredness of the type contemplated in the IOM vision. Perhaps the apparent British norms are just fine for Britain, and perhaps the pursuit of patient centeredness does not belong on the NHS agenda. But I doubt that. The next phase of development of a better NHS will go farther and faster, in my view, if stakeholders commit to a new level of control by patients and families of their own information and destinies in health care. It is important to know that British patients will not, in the first instance, demand that. They are trained too well. The question is not if they will ask, but rather if—once offered a new level of control and self-efficacy—they and the clinicians will come to appreciate the advantages of a new relationship that neither would have thought to request.

Linking the improvement of care to changes in professional education

It is as important to build a future as it is to heal the present. In health care the ''future'' refers to our young

professionals—doctors, nurses, therapists, and managers—who will inherit the NHS when we rest. From the viewpoint of improvement, and in pursuit of the ''STEEEP'' aims, our young professionals are emerging ill prepared to help. The education of health professionals generally lacks focus on the skills in systems thinking, statistical thinking, measurement, cooperation, group process, teamwork, and pragmatic ''real time science,'' to name but a few disciplines that provide the foundation for effective citizenship in improvement. The result of missing this knowledge is a workforce that too often seems resistant to change and that lacks sufficient capacity to change the work it does.

So far, as I see it, the processes of change underway in the NHS lack effective connection to consonant changes in the education of young professionals. The omission is costly now, and will be more costly in the future as the workforce continues to be ill prepared to cope with—let alone to lead—a new, evidence based, reliable, patient centered, efficient, and safe system of care. That can easily change in the UK, but only with a totally new level of communication with and involvement of the agencies and leaders who are stewards of the educational systems—the Royal Colleges and others. Very promising changes are now underway in the relationships between the Royal College of Physicians and the leaders of the NHS, and these bode well for the future.

CONCLUSION

I do predict success for the UK in its efforts to build what can become the best healthcare system in the world—nothing less. The task is well started. These three adjustments—to organize care far better at the community level, to raise the bar on patient centeredness beyond what British patients may at first ask for, and to welcome and embed into the improvement process an agenda for change in the education of young professionals—will not be easy, but they are important enough to tackle hard and soon.

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International guidelines

Challenges for an international guidelines collaboration

R Thomson

The Guidelines International Network is a welcome development for improving the quality of health care, but many challenges lie ahead

The emergence of evidence based guidelines may be one of the great successes of the evidence based medicine movement. We now have a mature process of development using literature review and appraisal, aligning strength of evidence and grading of recommendations. This has become an international movement and this global expansion is reflected in the development of the Guidelines International Network reported in this issue of *QSHC*.[1]

There have, indeed, been considerable successes, perhaps exemplified by the groundbreaking work of the National Institute of Clinical Excellence in the UK, building on earlier crafting of structured evidence based guidelines methods.[2 3] This industry was fashioned on the background of concerns about unexplained variations in practice and on the exponential growth of information with the problem for clinicians of remaining up to date with reading and assimilating the immense literature, let alone being able to appraise or assess it.[4] Studies had shown that guidelines available were often widely variable in their content and in their likely impact upon quality of care if applied in practice.[5 6] Early guidelines development, based primarily on consensus methods, was found to be wanting and unlikely to produce valid guidelines.[7]

A poorly developed guideline could be as risky to the public health as a poorly developed drug, where there are extensive regulatory schemes for drug development and approval worldwide. Structured quality assured guideline development, perhaps led by national agencies, would solve these problems and be a more cost effective and safe way of providing valid guidance. More sophisticated and structured approaches have now taken precedence, although they are costly to undertake. Since its inception, NICE has produced over 40 evidence based guidelines. Other bodies have adopted or adapted this approach, both within and outside the UK. Similarly, there has been international development of an instrument to support guidelines appraisal (the AGREE instrument).[8] On the back of this effective international collaboration has grown the latest development—the Guidelines International Network—with the laudable objective ''to protect the health of the general public by seeking to improve the quality of health care''.[1]

But all is not well with the movement. NICE has received criticism in the UK for its perceived failure to support effective dissemination of its guidance—a little unfair since it was not initially responsible for this.[9] Nonetheless, it is now trying to address this key issue. Furthermore, the dissemination of full guidelines, formally targeted at users, may not be read by the clinicians at whom they are targeted—they may even prefer the patient summary versions. This is hardly surprising given the size of modern guidelines. A recent editorial in the *BMJ* graphs out the growth in size of hypertension guidelines as newer versions have been published in the UK and abroad.[10] The second British Hypertension Society guidelines in 1993 were five pages long; the latest version in 2004 extends to 46 pages. There is therefore a problem for the dissemination and implementation of guidelines even if the development processes have been markedly improved.

Furthermore, evidence for the effectiveness of nationally developed guidelines is as yet incomplete, with some